CLAIM FORM

Section I - Instructions

This Form must be received by the Settlement Administrator no later than May 20, 2024.

This Claim Form may be submitted in one of two ways:

1. If you received a notice with a Unique ID, you can submit you claim Electronically through www.choicehealthtcpasettlement.com

2. Mail to: Choice Health TCPA Settlement, c/o A.B. Data, Ltd., P.O. Box 170600, Milwaukee, WI 53217.

To be effective as a Claim under the proposed settlement, this form must be completed, signed, and sent, as outlined above, **no later than May 20, 2024**. If this Form is not postmarked or submitted by this date, you will remain a member of the Class but will not receive any payment from the Settlement.

Section II - Class Member Information

Claimant Name (Required):

____

Unique ID Number: (Required):

____

Current Contact Information

Street Address (Required):

____

City (Required): **State (Required):** **Zip Code (Required)**

____

Preferred Phone Number (Required):

(________) __________ - ____________________

Your contact information will be used by the Settlement Administrator to contact you, if necessary, about your Claim. Provision of your email address is optional. By providing contact information, you agree that the Settlement Administrator may contact you about your Claim.

Section III – Confirmation of Class Membership

Telephone Number(s) for which you were the regular user or subscriber from May 2, 2019 through February 20, 2024:

(   )   -   (   )   -

(   )   -   (   )   -

Section IV – Required Affirmations

IF SUBMITTED BY U.S. MAIL:

I agree that, by submitting this Claim Form, the information in this Claim Form is true and correct to the best of my knowledge. I understand that my Claim Form may be subject to audit, verification, and Court review. I am aware that I can obtain a copy of the full Notice and Settlement Agreement at www.ChoiceHealthTCPASettlement.com, writing to the Settlement Administrator, Choice Health TCPA Settlement, c/o A.B. Data, Ltd., P.O. Box 170600, Milwaukee, WI 53217, or calling 1-877-388-1712

Dated:____________________ Signature: _____________________________

SETTLEMENT ADMINISTRATOR ADDRESS (*where to send the completed form if submitting by mail*):

Choice Health TCPA Settlement
c/o A.B. Data, Ltd
P.O. Box 170600
Milwaukee, WI 53217